


Exhibit 86

CONTRACT DISCREPANCY REPORT				
1. CONTRACT NUMBER DRO IGSA-06-00005		2. REPORT NUMBER FOR THIS DISCREPANCY 15-0001		
3. TO (Contractor and Manager's Name) CORRECTION CORPORATION OF AMERICA Warden Shelton Richardson		4. FROM (Name of QAE) David L. Graumenz JR		
5. DATES (YYYYMMDD)				
a. PREPARED 20150305	b. RETURNED BY CONTRACTOR		c. ACTION COMPLETE	
6. DISCREPANCY OR PROBLEM (Describe in detail. Include reference to PWS Directive; attach continuation sheet if necessary.) See Attachment.				
7. SIGNATURE OF CONTRACTING OFFICER				
8a. TO (Contracting Officer) Brandiss Smith		b. FROM (Contractor) Correction Corporate of America		
9. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. (Cite applicable Q.C. program procedures or new Q.C. procedures. Attach continuation sheet(s) if necessary.)				
10. SIGNATURE OF CONTRACTOR REPRESENTATIVE 				b. DATE (YYYYMMDD) 20150305
11. GOVERNMENT EVALUATION (Acceptance, partial acceptance, reflection. Attach continuation sheet(s) if necessary)				
12. GOVERNMENT ACTIONS (Reduced payment, cure notice, show cause, other)				
13. CLOSE OUT				
	NAME (1)	TITLE (2)	SIGNATURE (3)	DATE (YYYYMMDD) (4)
a. CONTRACTOR NOTIFIED				
b. QAE				
c. ACO				

CDR Attachment DRO IGSA-06-00005 15-001

"The 2011 Performance-Based National Detention Standards (PBNDS), Classification, Section V. F. 3, states: "... High custody detainees shall not be assigned work duties outside their assigned living areas. High custody detainees: are considered high risk," and "are always monitored and escorted..."

On March 3, 2015, a Health Services provider reported to the Health Services Administrator (HSA) that, on March 2, 2015, at approximately 10:50 p.m., she was proceeding from Health Services to the parking lot for her break. As she entered the visitation sallyport, she came face-to-face with "several", unsupervised, high-security (red uniform), detainees. According to the provider, she passed amongst the detainees, and through the second slider (nearest the front lobby) without incident; however, the provider stated that, as she was returning from the front lobby, the detainees were still working in the sallyport. Thus, she opted to detour through the administrative area, bypassing the visitation sallyport and the detainees.

Upon receipt of this information, on March 3, 2015, the Detention Services Manager (DSM) reviewed video recordings of the specified area, at the specified date and time. Upon the DSM's review, the provider's allegations were confirmed in that, eight, high-security, detainees, were observed working, unsupervised, in the visitation sallyport. Furthermore, the provider was observed proceeding through the sallyport where, at one point, she was secured between the two sliders with the detainees. She was then observed proceeding through the forward slider (nearest the front lobby), whereas the detainees had the opportunity for egress – all the way to the front gate (at a minimum).

As the Stewart Detention Center has been in compliance with this standard, since the inception of the PBNDS (2011 and 2008), it is apparent that this violation was deliberate."